



Send completed forms
to DOH Communicable
Disease Epidemiology
Fax: 206-418-5515

Haemophilus Influenzae

County _____

LHJ Use ID _____

☐ Reported to DOH

Date ____/____/____

LHJ Classification

☐ Confirmed

☐ Probable

By: ☐ Lab ☐ Clinical

☐ Other: _____

Outbreak # (LHJ) _____ (DOH) _____

DOH Use ID _____

Date Received ____/____/____

DOH Classification

☐ Confirmed

☐ Probable

☐ No count; reason: _____

REPORT SOURCE

Initial report date ____/____/____

Reporter (check all that apply)

☐ Lab ☐ Hospital ☐ HCP

☐ Public health agency ☐ Other

OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation
start date:
____/____/____

Reporter name _____

Reporter phone _____

Primary HCP name _____

Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____

Address _____ ☐ Homeless

City/State/Zip _____

Phone(s)/Email _____

Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____

Phone: _____

Occupation/grade _____

Employer/worksite _____ School/child care name _____

Birth date ____/____/____ Age _____

Gender ☐ F ☐ M ☐ Other ☐ Unk

Ethnicity ☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race (check all that apply)

☐ Amer Ind/AK Native ☐ Asian

☐ Native HI/other PI ☐ Black/Afr Amer

☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ____/____/____ ☐ Derived Diagnosis date: ____/____/____ Illness duration: _____ days

Signs and Symptoms

Y N DK NA

☐ ☐ ☐ ☐ Fever Highest measured temp: _____ °F

Type: ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk

☐ ☐ ☐ ☐ Conjunctivitis

☐ ☐ ☐ ☐ Eyes sensitive to light (photophobia)

☐ ☐ ☐ ☐ Other symptoms consistent with illness: _____

Hospitalization

Y N DK NA

☐ ☐ ☐ ☐ Hospitalized for this illness

Hospital name _____

Admit date ____/____/____ Discharge date ____/____/____

Y N DK NA

☐ ☐ ☐ ☐ Died from illness Death date ____/____/____

☐ ☐ ☐ ☐ Autopsy Place of death _____

Clinical Finding

Y N DK NA

☐ ☐ ☐ ☐ Bacteremia

☐ ☐ ☐ ☐ Meningitis

☐ ☐ ☐ ☐ Pneumonia or pneumonitis

X-ray confirmed: ☐ Y ☐ N ☐ DK ☐ NA

☐ ☐ ☐ ☐ Epiglottitis

☐ ☐ ☐ ☐ Otitis media (otitis media alone does not meet
the case definition for H. influenzae)

☐ ☐ ☐ ☐ Cellulitis

☐ ☐ ☐ ☐ Pericarditis or pericardial effusion

☐ ☐ ☐ ☐ Osteomyelitis

☐ ☐ ☐ ☐ Septic arthritis

☐ ☐ ☐ ☐ Coma

☐ ☐ ☐ ☐ Admitted to intensive care unit

☐ ☐ ☐ ☐ Mechanical ventilation or intubation required
during hospitalization

Vaccination

Y N DK NA

☐ ☐ ☐ ☐ Vaccine up to date for Hib

Date last vaccine prior to illness: ____/____/____

doses Hib vaccine prior to illness: _____

Vaccine series not up to date reason:

☐ Religious exemption

☐ Medical contraindication

☐ Philosophical exemption

☐ Previous infection confirmed by laboratory

☐ Previous infection confirmed by physician

☐ Parental refusal ☐ Under age for vaccination

☐ Other: _____

☐ Unk

Laboratory

Collection date ____/____/____

P = Positive O = Other, unknown

N = Negative NT = Not Tested

I = Indeterminate

P N I O NT

☐ ☐ ☐ ☐ ☐ Isolation of H. influenzae from a normally
sterile site Site: _____

Serotype: _____

Antibiotic resistance testing of isolate:

Ampicillin resistance ☐ Y ☐ N ☐ NT/Unk

Chloramphenicol resistance ☐ Y ☐ N ☐ NT/Unk

Rifampin resistance ☐ Y ☐ N ☐ NT/Unk

☐ ☐ ☐ ☐ ☐ H. influenzae type b antigen (CSF) [Probable]

NOTES

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forward and backward to figure probable exposure and contagious periods

Days
from
onset:

Exposure period

-7 -1

o
n
s
e
t

Contagious period*

As long as organisms are present (may be prolonged)

Calendar dates:

* If treated, 24-48 hours after onset of effective antibiotic therapy

EXPOSURE (Refer to dates above)

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine

Out of: ☐ County ☐ State ☐ Country

Destinations/Dates: _____

Y N DK NA

☐ ☐ ☐ ☐ Does the case know anyone else with similar symptoms or illness

Y N DK NA

☐ ☐ ☐ ☐ Contact with lab confirmed case

☐ Casual ☐ Household ☐ Sexual

☐ Needle use ☐ Other: _____

☐ Patient could not be interviewed

☐ No risk factors or exposures could be identified

Most likely exposure/site: _____

Site name/address: _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PATIENT PROPHYLAXIS / TREATMENT

Y N DK NA

☐ ☐ ☐ ☐ Treated for nasopharyngeal carriage

PUBLIC HEALTH ISSUES

Y N DK NA

☐ ☐ ☐ ☐ Attends child care or preschool

☐ ☐ ☐ ☐ Do any household members or close contacts work at or attend childcare or preschool

☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

☐ Prophylaxis of appropriate contacts recommended

recommended prophylaxis: _____

receiving prophylaxis: _____

completing prophylaxis: _____

NOTES

Investigator _____ Phone/email: _____

Investigation complete date ____/____/____

Local health jurisdiction _____

Record complete date ____/____/____